John Elias Baldacci
Governor

Maine Department of Health and Human Services

Office of MaineCare Services
442 Civic Center Drive
11 State House Station
Augusta, ME 04333-0011

Brenda M. Harvey
Commissioner

J. Michael Hall
Acting Director

HIPAA EDI Registration Application Instructions for 837 Institutional Providers

Section/Field Name	Instructions for Completion
1. **Status**	All providers **must** check "Enrollment" for new HIPAA Compliant EDI Registration. "Change Existing Information" applies to Changes to EDI Registration information for future changes.
2. **Trading Partner Information** **Name**	Enter the name of the applicant. If enrolling an individual practitioner, enter the individual's name and title as it appears on the license: If the applicant is enrolling as a clinic/group, hospital, billing provider, etc., use license or Medicare certification name, if this is a requirement for the program. Use the business/DBA name if a license or Medicare certification is not required.
Tax ID Number	Enter your federal tax ID number.
Address	A street address must be entered in this field, either alone or with a post office box or route number. Please include Suite #. Enter the applicant's primary location address **A post office box number alone is not an acceptable address,** since correspondence may be sent by a commercial carrier such as UPS.
City, State, Zip	Enter the City, State and Zip corresponding to the applicant's address.
Billing Office or IT Office Contact Information	Enter primary and secondary contact information. These are the persons who will be contacted if there are questions related to HIPAA EDI transactions.
3. **All Billing Providers**	Enter all active billing numbers. Please attach additional pages if necessary.
4**. Billing Providers planning to submit directly to MaineCare**	**Only Billing Providers directly submitting claims** Enter your Software Vendor Name, contact phone number and contact e-mail.
5. **Select Requested HIPAA Transactions**	Currently only 837-I (Health Care Claim-Institutional) is available for check off. As Additional Transactions become available, change forms will be provided for the purpose of selecting these additional transaction options.
6. **Telecommunication Type**	Please check appropriate box.
7. **Terms of Use**	Providers authorized representative must sign this form. Please keep a copy for your records.

****Please complete and sent the EDI Registration Application as well as TWO (2) Copies of the Trading Partner Agreement to:**

Provider Enrollment Unit
Office of MaineCare Services
Maine Department of Health and Human Services
442 Civic Center Drive
Augusta, ME 04333-7902
(800) 321-5557 option 6

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MaineCare EDI Registration Forms for 837 Institutional Billing Providers

Provider Enrollment Unit **Office of MaineCare Services** **Department of Health and Human Services** **442 Civic Center Drive** **Augusta, ME 04333-7902**	**Phone: (800) 321-5557** Fax: (207) 287-8450

1. **Status** ☐ **Enrollment** -or- ☐ Change Existing information -or- ☐ Add Additional Providers (for Billing Agents)

2. **Trading Partner Information**

Name _____ Tax ID Number _____-_____

Address (including Suite #) _____

City _____ State _____ Zip Code _____

2a. **Billing Office or Information Technology (IT) Office Contact Information**

Primary Contact Name	Secondary Contact Name
Primary E-Mail Address	Secondary E-Mail Address
Phone	Phone
Fax	Fax

3. All Billing Providers: Please enter all active MaineCare billing numbers.
(Attach Additional Sheets if Necessary)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

4. Billing Providers planning to submit directly to MaineCare

Software Vendor Name _____

Contact Person _____

Phone # _____ E-Mail _____

5. **Select Requested HIPAA Transactions**: (Additional Transactions may be requested upon their availability. Change forms will be provided for this purpose.)

☐ 837-I Health Care Claim: Institutional

☐ 835- Health Care Payment Advice

** 997- Functional Acknowledgement and TA1- Interchange Acknowledgement will be posted on the Momentum "Out Folder" for provider access.

6. **Telecommunication Type**

☐ Direct Dial (Direct Modem Connection) ☐ Internet via Secure FTP

** Providers who bill directly to MaineCare will no longer be able to use Internet Explorer to transmit claims. In order for HIPAA Compliance, claims must be submitted through a secure File Transfer Protocol (FTP).

7. **Terms of Use**

Providers are required to report in advance if they will begin or discontinue use of a clearinghouse or billing agent for submission or receipt of any of their HIPAA EDI transactions, if they will begin to use a different clearinghouse or billing agent for any HIPAA EDI transactions, if they wan to begin to use the HIPAA claim or remittance advice transaction, or if they plan to discontinue use of one or more HIPAA EDI transactions, and that this notification must be in writing and submitted via mail or fax. ** ALL TRADING PARTNER AGREEMENTS MUST BE SENT VIA MAIL. DO NOT FAX A TRADING PARTNER AGREEMENT.

The authorized signer below attests to the accountability of the person requesting a Sender ID and Password to access MaineCare's secure FTP server for sending and/or receiving MaineCare Data. Use of the EDI is limited to the person/provider to whom the number and password is issued and a provider will be held responsible for fraudulent actions performed in the event a provider does give another person or entity access to (or negligently allows access to) that EDI number and password; and the provider's EDI number and password may not be given to the purchaser in the event of sale or lease of the provider's practice/facility. The authorized signer is responsible for understanding the Terms of Use and ensuring that the Sender ID and password are not shared.

BY: _____ _____
Signature Date

_____ _____
Name Printed Title

INTERNAL USE ONLY

A. PEU: Date Received _____ ❒ Documents Complete Date Sent to OIT: _____By_____

Submitter ID #:_____

INTERNAL USE ONLY

B. OIT: ❒ PASS Date: _____ Date Authorized for Production Claims Submittal: _____

New URL Address:_____ New User ID:_____ New Password:_____

INTERNAL USE ONLY

C. PEU: Acceptance Letter Sent By _____ Date:_____

ENROLLMENT COMPLETE